TITLE 10: CALIFORNIA CODE OF REGULATIONS
CHAPTER 5.5 MAJOR RISK MEDICAL INSURANCE PROGRAM

Article 1. Definitions

Section 2698.100 is amended to read:

2698.100. Definitions

For the purposes of this part:

(a) "Appellant" means an applicant, subscriber, enrolled dependent, or dependent subscriber who has filed an appeal with the program.

(b) "Applicant" means an individual who has filed an application for major risk medical coverage with the program.

(c) "Authorized Representative" means any person or entity who has been designated, in writing, by the appellant to act on his/her behalf or individuals who have appropriate power of attorney or legal conservatorship.

(d) "Board" means the Managed Risk Medical Insurance Board.

(e) “Certificate of Program Completion” means a certificate issued by the Program to persons leaving the Program after 36 consecutive months of coverage.

(f) "Coverage" means the payment by the program or other health plan or insurer for medically necessary services provided by institutional and professional providers.

(g) “Creditable coverage” means:

(1) Any individual or group policy, contract or program, that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, disability income, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement, Medicare supplement, long-term care, dental, vision, coverage

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issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.

(3) The Medicaid program pursuant to Title XIX of the Social Security Act.

(4) Any other publicly sponsored program, provided in this state or elsewhere of medical, hospital and surgical care.

(5) 10 U.S.C.A. Chapter 55 (commencing with Section 1071) Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

(6) A medical care program of the Indian Health Service or of a tribal organization.

(7) A state health benefits risk pool.

(8) A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901)(FEHBP).

(9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(l) of the Public Health Service Act, as amended by Public Law 104-191.

(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.A. 2504(e)).

(h) "Day" means calendar day unless specified otherwise.

(i) "Dependent" means:

(1) The spouse or registered domestic partner of a subscriber or applicant at the time of application.

(2) An unmarried child under the age of 23 at the time of application, who is an adopted child or stepchild pursuant to subsection (C) below, or a natural child who:

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(A) lives with the subscriber or applicant; or

(B) is economically dependent upon the subscriber or the applicant.

(C) 1. A child shall be considered to be adopted from the date on which the adoptive child's birth parents or other appropriate legal authority signs a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or a relinquishment form, granting the subscriber or applicant, or the spouse or registered domestic partner of a subscriber or applicant, the right to control health care for the adoptive child or, absent this written document, on the date there exists evidence of the right of the subscriber or applicant, or the spouse or registered domestic partner of a subscriber or applicant, to control the health care of the child placed for adoption.

2. A child shall be considered a stepchild upon the subscriber's or applicant's marriage to the child's natural or adoptive parent or when the subscriber or applicant becomes the registered domestic partner of the child's natural or adoptive parent.

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(3) An unmarried child over the age of 23 at the time of application, who is an adopted child or stepchild pursuant to (2)(C) of this section, or a natural child who at the time of attaining age 23 was incapable of self-support because of physical or mental disability which has existed continuously from a date prior to attainment of age 23.

(j) "Dependent Subscriber" means an enrolled dependent that has maintained eligibility pursuant to section 2698.205.

(k) "Disenroll" means termination from coverage by the program.

(l) "Eligible" means the applicant is qualified to be enrolled along with dependents in a participating health plan.

(m) "Enroll" means to accept an individual as a subscriber or as a dependent by notifying a participating health plan to accept the applicant and dependents, if any, for coverage.

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(n) "Executive Director" means the Executive Director for the Board.

(o) "Fee-for-service plan" means either of the following:

(1) Service benefit plans under which retrospective payment is made by a carrier under contracts with physicians, hospitals, or other providers of health services rendered to subscribers.

(2) Indemnity benefit plans under which a carrier agrees to pay retrospectively certain sums of money, not in excess of actual expenses incurred, for health services.

(p) "Health maintenance organization" means either of the following:

(1) Comprehensive group-practice prepayment plans which offer benefits, in whole or in substantial part, on a prepaid basis, with professional services thereunder provided by physicians or other providers of health services practicing as a group in a common center or centers. This group shall include physicians representing at least three major medical specialties who receive all or a substantial part of their professional income from the prepaid funds.

(2) Individual practice prepayment plans or network model prepayment plans which offer health services in whole or in part on a prepaid basis, with professional services thereunder provided by individual physicians or groups of physicians or other providers of health services who agree to accept the payments provided by the plans as full payment for covered services rendered by them.

(q) "Health plan" means a private insurer holding a valid outstanding certificate of authority from the Insurance Commissioner, a nonprofit hospital service plan qualifying under Chapter 11A (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code, a nonprofit membership corporation lawfully operating under the Nonprofit Corporation Law (Division 2 (commencing with Section 5000) of the Corporations Code), or a health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code, which is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal health care services under insurance policies or contracts, medical and hospital service agreements, or membership contracts, in consideration of premiums or other periodic charges payable to it.

(r) "Medicare" means the Health Insurance For The Aged provided under Title XVIII of the Social Security Act; "Part A" means Hospital Insurance

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as defined in Title XVIII of the Social Security Act; and "Part B" means Medical Insurance as defined in Title XVIII of the Social Security Act.

(s) "Participating health plan" means a health plan which has a contract with the program to administer major risk medical coverage for program subscribers. Participating health plans are categorized as either fee-for-service plans or health maintenance organizations as defined in Section 2698.100 (p) or (q) respectively.

(t) “Pilot Program” means the program established by Health and Safety Code section 1373.62 and Insurance Code section 10127.15.

(u) “Pilot Program health plan” means any health care service plan or health insurer who has enrolled a program graduate into the Pilot Program and a Pilot Program standard benefit plan.

(v) “Pilot Program standard benefit plan” means a benefit package that meets the criteria of Health and Safety Code section 1373.62(c) or Insurance Code section 10127.15 (c).

(w) "Pre-existing condition" means any condition for which medical advice, diagnosis, care, or treatment was recommended or received during a six month period immediately preceding the effective date of coverage.

(x) "Pre-existing condition exclusion period" means that period of time for which there is no coverage for a pre-existing condition.

(y) "Post-enrollment waiting period" means that period of time between the date of enrollment and the date coverage begins.

(z) "Program" means the California Major Risk Medical Insurance Program.

(aa) “Program Graduate” means:

(1) A subscriber in the Program who has completed 36 consecutive months of coverage and has been issued a Certificate of Program Completion by the Program; or

(2) A dependent subscriber who has completed a total of 36 consecutive months of coverage in the program, and has been issued a Certificate of Program Completion by the Program.

(bb) “Program Graduate dependent” means an enrolled dependent who has completed 36 consecutive months of coverage and has been issued a Certificate of Program Completion by the Program at the same time as the subscriber.

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(cc) "Registered domestic partner" means a person who either (i) has filed a Declaration of Domestic Partnership with the Secretary of State which meets the criteria specified by Family Code section 297 and the partnership has not been terminated pursuant to Family Code section 299, or (ii) is a member of a domestic partnership validly formed in another jurisdiction which is cognizable as a valid domestic partnership in this state pursuant to Family Code section 299.2.

(dd) "Resident of the State of California" means a person who is present in California with intent to remain present except when absent for transitory or temporary purposes. However, a person who is absent from the state for a consecutive period greater than 210 days shall not be considered a resident.

(ee) "Standard average individual rate" means that rate a participating health plan estimates it would charge the general public for individual, non-group coverage for the benefits described in the program contract with the participating health plan.

(ff) "Standard monthly administrative fee" means the weighted monthly average per person administrative fee paid by the Pilot Program to participating Pilot Program health plans and calculated in accordance with section 2698.602(d).

(gg) "Subscriber" means an individual who is eligible for and receives major risk medical coverage through the program. "Subscriber" does not include an individual receiving major risk medical coverage through the program as an enrolled dependent of a subscriber. An individual who is enrolled but not yet receiving coverage due to a post-enrollment waiting period is considered a subscriber.

(hh) "Subscriber contribution" means the amount paid by a subscriber or a dependent subscriber on a periodic basis to the program for coverage for a subscriber and/or enrolled dependents, if any, or for a dependent subscriber.

(ii) "Unique Identification Number (UIN)" means a number assigned by the Program to each Program Graduate's Certificate of Program Completion to be used in the Pilot Program to track each Program Graduate for payment and reporting purposes.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code; ASSEM. Bill No. 1401(stats. 2002, ch. 794, Sec. 21). Reference: Sections 10900, 10127.15, 12705, 12711, 12712, 12725, 12726 and 12730, Insurance Code; 1373.62, Health and Safety Code; Sections 297, 299 and 299.2, Family Code.

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Article 2. Eligibility, Application, and Enrollment

2698.200. Basis of Eligibility.

(a) All eligibility requirements contained herein shall be applied without regard to sex, race, creed, color, sexual orientation, health status, national origin, occupation, or occupational history of the individual applying for the program.

(b) To be eligible for the program, an applicant shall meet the requirements of either (1) or (2):

(1) Meet all of the following requirements:

(A) Be a resident of the State of California; and

(B) Not be eligible for Part A and Part B of Medicare, except those applicants on Medicare solely because of end-stage renal disease; and

(C) Not be eligible to purchase any health insurance for continuation of benefits under the provisions of Health and Safety Code section 1366.20 et. seq., or under the provisions of Insurance Code section 10128.50 et. seq. or have exhausted any health insurance for continuation of benefits under the provisions of 29 US Code 1161 et. seq.; and

(D) Be unable to secure adequate private coverage. An individual shall be deemed unable to secure adequate private health coverage if the individual within the previous 12 months:

1. Has been denied individual coverage; or

2. Has been involuntarily terminated from health insurance coverage for reasons other than nonpayment of premium or fraud; or

3. Has been offered an individual, not a group, health insurance premium rate in excess of the subscriber rate for the individual's first choice participating health plan.

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(2) Be a dependent of an individual meeting the requirements of (b)(1) of this section.

(c) To remain eligible a subscriber, enrolled dependent or dependent subscriber shall:

(1) Remain a resident of the State of California; and

(2) Not become eligible for Part A and Part B of Medicare, except those applicants who become eligible for Medicare solely because of end-stage renal disease; and

(3) Not exceed a total of 36 consecutive months of enrollment from his/her respective start of coverage date in the program as required by section 2698.204(a)(7); and

(4) Make subscriber contribution payments as required by section 2698.403.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Section 12711, 12725, and 12733, Insurance Code; Sections 297, 299 and 299.2, Family Code.

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2698.201. Application

Section 2698.201 is amended to read:

(a) The Board shall establish an application review process which assures timely action on applications. The program shall complete the application review process within 30 days of receipt of the application and payment of the initial subscriber contribution.

(b) To apply for the program an individual shall submit:

(1) all information, documentation, and declarations necessary to determine program eligibility as set forth in subsection (d) of this section, and

(2) a check or money order for an amount equal to the initial subscriber contribution for the individual's first choice participating health plan.

(c) A complete application is one that meets the requirements of (b)(1) and (b)(2) of this section. All applications shall be reviewed for completeness upon receipt by the program.

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(1) If the application is complete, it will be reviewed for an eligibility determination.

(2) An incomplete application shall be returned to the individual and shall not be processed.

(d) (1) The applicant shall use the application form entitled California Major Risk Medical Insurance Program Enrollment Application.

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(2) The applicant shall provide the following information:

(A) The applicant's full name.

(B) The applicant's current home address including house or unit number, street, city, county, state, and zip code.

(C) The applicant's date of birth.

(D) The applicant's sex.

(E) The applicant's marital or registered domestic partnership status.

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(F) The applicant's home and/or business telephone number.

(G) If dependents are to be included in the coverage, the full names, dates of birth, sex, and relationship of the dependents to be covered.

(H) The name and address to which the bills for the subscriber contribution are to be sent, if different from the applicant's.

(I) Proof of rejection within 12 months of the date of application for health insurance coverage for reasons other than fraud or nonpayment of premium. The proof shall include a letter or other formal written communication from a health plan, documenting one or more of the following:

1. Having been denied health insurance coverage as an individual.

2. Having been involuntarily terminated from health insurance coverage.

3. Having been offered an individual, not a group, health insurance premium rate in excess of the

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subscriber rate for the individual's first choice participating health plan.

(J) An initialed declaration that the applicant is not eligible for Part A and Part B of Medicare, in accordance with subsection 2698.200(b)(1)(B).

(K) An initialed declaration that the applicant is a resident of the State of California.

(L) An initialed declaration that the applicant will abide by the rules of participation, utilization review process, and dispute resolution process of any participating health plan in which the applicant is enrolled.

(M) An initialed declaration that the applicant is not, to the applicant's knowledge, being excluded from a group for the purpose of being made eligible for the program.

(N) An initialed declaration that the applicant has reviewed the benefits offered by the participating health plans and the subscriber contribution rates.

(O) An initialed declaration that the applicant understands and will follow the rules and regulations of the program.

(P) Name and address of the applicant's primary employer, if employed.

(Q) The applicant's occupation, if employed.

(R) An initialed declaration that the applicant is not currently eligible to purchase any health insurance for continuation of benefits under the provisions of Health and Safety Code section 1366.20 et. seq., or under the provisions of Insurance Code section 10128.50 et. seq. or has exhausted any health insurance for continuation of benefits under the provisions of 29 US Code 1161 et. seq..

(S) An initialed declaration that the applicant has not been terminated from a standard benefit plan available under the provisions of Health and Safety Code section 1373.62 or Insurance code section 10127.15 within the last 12 months due to non-payment of premiums or as a result of the applicant's request to voluntarily disenroll or as a result of fraud.

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(T) An indication of the applicant's selected participating health plan.

(U) If an applicant is not currently eligible for the program, but anticipates becoming eligible, the applicant shall explain and document the reason or reasons, and provide the date on which eligibility will occur.

(V) The applicant or the applicant's parent, conservator, or guardian shall sign and date the application stating that the information given is true and correct.

(3) The following information is requested but not mandatory, and will be used for identification and administrative purposes:

(A) The applicant's ethnicity.

(B) The applicant's social security number.

(C) The dependent's social security number, if dependents are to be included in the coverage.

(e) In order for the program to determine that a pre-existing condition exclusion or a post-enrollment waiting period should be waived, or partially waived, each individual applying for coverage must provide one of the following:

(1) Documentation that the individual had prior creditable coverage, or

(2) Documentation that the individual has been covered by a similar plan sponsored by another state before becoming a resident of the State of California.

(f) Applications may be submitted at any time. An applicant shall not be enrolled nor shall the applicant be placed on a waiting list until the applicant has fulfilled all of the requirements for eligibility. Once the requirements for eligibility are fulfilled, applicants shall be enrolled or placed on a waiting list in order of the date of receipt of the completed application.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Sections 12711, 12725 and 12728, Insurance Code; Sections 297, 299 and 299.2, Family Code.

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2698.206. Dependent Coverage

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Section 2698.206 is amended to read:

(a) (1) Dependents may be enrolled:

(A) Within sixty (60) days of the date the individual became the subscriber's dependent; or

(B) Within sixty (60) days of the termination of a dependent's other health care coverage.

(2) A subscriber wishing to enroll additional dependents shall notify the program in writing of the full names, dates of birth, sex, social security numbers (not mandatory), and relationship of the dependents to be enrolled. Social Security numbers and other personal information are used for identification and administrative purposes.

(3) In order for the program to determine that a pre-existing condition exclusion or post-enrollment waiting period should be waived, or partially waived, the subscriber may also provide the documentation required by section 2698.201(e) for each dependent to be added. If no documentation is provided, the dependent shall be subject to the maximum pre-existing condition exclusion or post-enrollment waiting period described in section 2698.303. Dependents age 18 and under are not subject to pre-existing condition exclusion or post-enrollment waiting periods.

(4) (A) Coverage for newborns and adopted children eligible pursuant to (a)(1) of this section shall begin upon birth or the date on which the adoptive child's birth parents or other appropriate legal authority signs a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or a relinquishment form, granting the subscriber or the subscriber' spouse or registered domestic partner, the right to control health care for the adoptive child or, absent this written document, on the date there exists evidence of the right of the subscriber or the subscriber's spouse or registered domestic partner, to control the health care of the child placed for adoption.

(B) Coverage for all other dependents eligible pursuant to (a)(1) of this section shall begin within 3 months of receipt of the notification to the program from the subscriber, and shall begin on the first day of a month, subject to the provisions of section 2698.303.

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(5) Subscribers shall be notified in writing by the program of the beginning date of coverage by the subscriber's health plan for enrolled dependents, and, if applicable, of any pre-existing condition exclusion period or post-enrollment waiting period. The notice shall caution the subscriber about discontinuing any existing coverage for dependents until full coverage by the subscriber's health plan has begun.

(6) The subscriber contribution shall be adjusted as of a dependent's beginning date of coverage by the program; unless the dependent added was a newborn or an adopted child.

(7) The subscriber contribution for a newborn or an adopted child who is enrolled pursuant to (a)(1)(A) of this section shall be adjusted as of the first day of the month following the child's birth or first day of the month following the date on which the adoptive child's birth parents or other appropriate legal authority signs a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or a relinquishment form, granting the subscriber or the subscriber' spouse or registered domestic partner, the right to control health care for the adoptive child or, absent this written document, on the first day of the month following the date there exists evidence of the right of the subscriber or the subscriber's spouse or registered domestic partner, to control the health care of the child placed for adoption.

(b) (1) A subscriber wishing to disenroll dependents shall notify the program of the full names, dates of birth, sex, social security numbers, and relationship of the dependents to be disenrolled. Disenrollment of dependents shall be subject to sections 2698.204(a)(1), 2698.204(a)(2) and 2698.204(c).

(2) The subscriber contribution shall be adjusted, if applicable, as of the date of a dependent's disenrollment by the program.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Section 12729, Insurance Code; Section 297, 299 and 299.2 Family Code

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Article 3. Minimum Scope of Benefits

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(a) Benefits shall be subject to such required copayments and deductibles as the Board may authorize subject to the following limits:

(1) The copayment shall not exceed 25 percent of the cost of covered services.

(2) Notwithstanding the provision contained in subsection (1), the Board may authorize health plans not utilizing a deductible to charge an office visit copayment of up to twenty-five dollars ($25).

(3) The deductible shall not exceed $500 annually for a household, which consists of a subscriber and any enrolled dependents or of a dependent subscriber.

(4) The sum of the copayment and deductible shall not exceed $2,500 annually for a subscriber or dependent subscriber or $4,000 annually for a subscriber and enrolled dependents.

(b) When a subscriber's or dependent subscriber's selected participating health plan is a plan that has contracts with certain listed providers from whom care is to be received for non-emergency conditions, and there are additional subscriber payments to providers other than those listed, such additional subscriber payments shall not be subject to the limits of this section.

NOTE: Authority cited: Sections 12711 and 12712 Insurance Code. Reference: Section 12718, Insurance Code

2698.301. Minimum Scope of Benefits

(a) The basic minimum scope of benefits offered by participating health plans to subscribers, dependent subscribers and enrolled dependents must comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975 including amendments as well as its applicable regulations, and shall include all of the benefits and services listed in this section. Except as required by the applicable statute and regulations, no other benefits shall be permitted to be offered by a participating health plan unless specifically provided for in the program contract with the participating health plan. The basic minimum scope of benefits shall be as follows:

(1) Hospital inpatient care in a hospital licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code, including all of the following benefits and services:

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(A) Semi-private room, including meals and general nursing services; and private room and special diets when prescribed as medically necessary.

(B) Hospital services, including use of operating room and related facilities, intensive care unit and services, labor and delivery room, and anesthesia.

(C) Drugs, medications, and parenteral solutions administered while an inpatient.

(D) Dressing, casts, equipment, oxygen services, and radiation therapy.

(E) Respiratory and physical therapy.

(F) Diagnostic laboratory and x-ray services.

(G) Special duty nursing as medically necessary.

(H) Administration of blood and blood products.

(I) Other diagnostic, therapeutic or rehabilitative services (including occupational, physical and speech therapy) as appropriate.

(J) Medically necessary inpatient alcohol and substance abuse.

(K) General anesthesia and associated facility charges in connection with dental procedures rendered in a hospital, when the clinical status or underlying medical condition of a subscriber, enrolled dependent or dependent subscriber requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital. This benefit is only available to subscribers, enrolled dependents or dependent subscribers under seven years of age; the developmentally disabled, regardless of age; and subscribers, enrolled dependents or dependent subscribers whose health is compromised and for whom general anesthesia is medically necessary, regardless of age.

Nothing in this section shall require a participating health plan to cover any charges for the dental procedure itself, including, but not limited to, the professional fee of the dentist.

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(2) Medical and surgical services, provided on an outpatient basis whenever medically appropriate, including all of the following:

(A) Physician services including consultations, referrals, office and hospital visits and surgical services performed by a physician and surgeon.

(B) Diagnostic laboratory services, diagnostic and therapeutic radiological services and other diagnostic services that shall include but not be limited to nuclear medicine, ultrasound, electrocardiography and electroencephalography.

(C) Dressings, casts and use of castroom, anesthesia, and oxygen services when medically necessary.

(D) Blood, blood derivatives and their administration.

(E) Radiation therapy and chemotherapy, of proven benefit.

(F) Comprehensive preventive care of adults and children.

i. Comprehensive preventive care of children shall be consistent with the most current Recommendations for Preventive Pediatric Health Care as adopted by the American Academy of Pediatrics.

ii. Comprehensive preventive care services for adults and children shall include periodic health evaluations, immunizations, and laboratory services in connection with periodic health evaluations.

iii. Immunizations for children shall:

a. Be consistent with the most current version of the Recommended Childhood Immunization Schedule/United States jointly adopted by the American Academy of Pediatrics and the Department of Health and Human Services, Centers for Disease Control and Prevention, Advisory Committee on Immunization Practices (ACIP).

b. Include immunizations required for travel as recommended by the ACIP.

iv. Immunizations for adults shall:

a. Be consistent with the most current recommendations of the Department of Health and Human Services, Centers for Disease Control and Prevention, Advisory Committee on Immunization Practices (ACIP).

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b. Include immunizations required for travel as recommended by the ACIP.

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(G) General anesthesia and associated facility charges in connection with dental procedures rendered in a surgery center setting, when the clinical status or underlying medical condition of a subscriber, enrolled dependent or dependent subscriber requires dental procedures that ordinarily would not require general anesthesia to be rendered in a surgery center setting. This benefit is only available to subscribers, enrolled dependents or dependent subscribers under seven years of age; the developmentally disabled, regardless of age; and subscribers, enrolled dependents or dependent subscribers whose health is compromised and for whom general anesthesia is medically necessary, regardless of age.

Nothing in this section shall require a participating health plan to cover any charges for the dental procedure itself, including, but not limited to, the professional fee of the dentist.

(H) Nothing in this section shall preclude the direct reimbursement of physician assistants, nurse practitioners or other advanced practice nurses who provide covered services within their scope of licensure.

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(3) Family planning services including a variety of prescriptive contraceptive methods approved by the federal Food and Drug Administration, and reproductive sterilization.

(4) Comprehensive maternity and perinatal care, including the services of a physician and surgeon, certified nurse midwife or nurse practitioner, and all necessary hospital services, including services related to complications of pregnancy, are covered services.

Nothing in this section shall preclude the direct reimbursement of nurse practitioners or other advanced practice nurses in providing covered services.

(5) Emergency care including out-of-area coverage. Emergency ambulance transportation including transportation provided through the "911" emergency response system.

(6) Reconstructive Surgery: Surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following;

(A) improve function.

(B) create a normal appearance to the extent possible.

Includes reconstructive surgery to restore and achieve symmetry incident to mastectomy.

(7) Prescription drugs, limited to drugs approved by the federal Food and Drug Administration, generic equivalents approved as substitutable by the federal Food and Drug Administration, or drugs approved by the federal Food and Drug Administration as Treatment Investigational New Drugs.
Also includes insulin, glucagon, syringes and needles and pen delivery systems for the administration of insulin, blood glucose testing strips, ketone urine testing strips, lancets and lancet puncture devices in medically appropriate quantities for the monitoring and treatment of insulin dependent, non-insulin dependent and gestational diabetes.

(8) Mental Health benefits are covered as follows:

(A) For severe mental illnesses, and serious emotional disturbances of children, inpatient services, outpatient services, partial hospitalization services and prescription

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medications. Severe mental illnesses include schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa.

(B) Except as specified in Subsection (A) above, mental health benefits are limited to the following:

1. Inpatient care for a period of 10 days in each calendar year.

2. 15 outpatient visits in each calendar year.

(9) Medical rehabilitation and the services of occupational therapists, physical therapists, and speech therapists as appropriate on an outpatient basis.

(10) Durable medical equipment, including prosthetics to restore and achieve symmetry incident to a mastectomy and to restore a method of speaking incident to a laryngectomy. Covered services also include blood glucose monitors and blood glucose monitors for the visually impaired for insulin dependent, non-insulin dependent and gestational diabetes; insulin pumps and all related necessary supplies; visual aids to assist the visually impaired with proper dosing of insulin and podiatric devices to prevent or treat diabetes complications.

(11) Home Health Services: Health services provided at the home by health care personnel. Includes visits by Registered Nurses, Licensed Vocational Nurses, and home health aides; physical, occupational and speech therapy; and respiratory therapy when prescribed by a licensed practitioner acting within the scope of his or her licensure.

(12) The following human organ transplants: corneal, human heart, heart-lung, liver, bone-marrow and kidney transplantation. Transplants other than corneal shall be subject to the following restrictions:

(A) Pre-operative evaluation, surgery, and follow-up care shall be provided at centers that have been designated by the participating health plan as having documented skills, resources, commitment and record of favorable outcomes to qualify the centers to provide such care.

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(B) Patients shall be selected by the patient-selection committee of the designated centers and subject to prior authorization.

(C) Only anti-rejection drugs, biological products, and other procedures that have been established as safe and effective, and no longer investigational, are covered.

(13) Hospice services pursuant to Health and Safety Code section 1368.2.

(14) This part shall not be construed to prohibit a plan's ability to impose cost-control mechanisms. Such mechanisms may include but are not limited to requiring prior authorization for benefits or providing benefits in alternative settings or using alternative methods.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Sections 12711and 12712, Insurance Code.

2698.302. Excluded Benefits

(a) Plans offered under this program shall exclude the following benefits unless specifically provided for in the program contract with the participating health plan:

(1) Services that are not medically necessary. "Medically necessary" as applied to the diagnosis or treatment of illness is an article or service that is not investigational and is necessary because:

(A) It is appropriate and is provided in accordance with accepted medical standards in the state of California, and could not be omitted without adversely affecting the patient's condition or the quality of medical care rendered; and

(B) As to inpatient care, it could not have been provided in a physician's office, in the outpatient department of a hospital, or in a lesser facility without adversely affecting the patient's condition or the quality of medical care rendered; and

(C) If the proposed article or service is not commonly used, its application or proposed application has been preceded by a thorough review and application of conventional therapies; and

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(D) The service or article has been demonstrated to be of significantly greater therapeutic value than other, less expensive, services or articles.

(2) Any services which are received prior to the enrollee's effective date of coverage.

(3) Custodial, domiciliary care, or rest cures for which facilities of a general acute care hospital are not medically required. Custodial care is care that does not require the regular services of trained medical or health professionals and that is designed primarily to assist in activities of daily living. Custodial care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self administered.

(4) Personal or comfort items, or a private room in a hospital unless medically necessary.

(5) Emergency facility services for nonemergency conditions.

(6) Those medical, surgical (including implants), or other health care procedures, services, drugs, or devices which are either:

(A) Services, products, drugs or devices which are experimental or investigational or which are not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question.

(B) Outmoded or not efficacious.

(7) Transportation except as specified in section 2698.301(a)(5).

(8) Implants, except cardiac pacemakers, intraocular lenses, screws, nuts, bolts, bands, nails, plates, and pins used for the fixation of fractures or osteotomies and artificial knees and hips; and except as specified in section 2698.301(a)(6).

(9) Sex change operations, investigation of or treatment for infertility, reversal of sterilization, and conception by artificial means.

(10) Eyeglasses, contact lenses (except the first intraocular lens following cataract surgery), routine eye examinations, including eye refractions, except when provided as part of a routine examination under "preventive care for minors," hearing aids,

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orthopedic shoes, orthodontic appliances, and routine foot care are excluded.

(11) Long-term care benefits including home care, skilled nursing care, and respite care, are excluded except as a participating health plan shall determine they are less costly alternatives to the basic minimum benefits.

(12) Dental services and services for temporomandibular joint problems are excluded, except for repair necessitated by accidental injury to sound natural teeth or jaw, provided that the repair commences within 90 days of the accidental injury or as soon thereafter as is medically feasible.

This language shall not be construed to exclude surgical procedures for condition directly affecting the upper or lower jawbone, or associated joints.

(13) Treatment of chemical dependency except as specified in section 2698.301 (a)(1)(J).

(14) Cosmetic surgery, except as specifically provided in section 2698.301(a)(6).

(b) Benefits which exceed $75,000 in a calendar year under the program for a subscriber, or a subscriber's enrolled dependent or a dependent subscriber shall be excluded.

(c) Benefits which exceed $750,000 in a lifetime under the program for a subscriber, a subscriber's enrolled dependent or dependent subscriber shall be excluded. Benefits received prior to January 1, 1999 shall be counted towards the $750,000 lifetime maximum.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Sections 12711and 12712, Insurance Code.

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